

43 - Psychosis associated with stimulant drugs

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534 The Maudsley® Prescribing Guidelines in Psychiatry CHAPTER 4 Detoxification and dependence A withdrawal syndrome is common in those who are dependent. Treatment should focus on symptomatic relief, although many symptoms of amphetamine withdrawal (low mood, listlessness, agitation, irritability, fatigue, etc.) are short-lived and may not be amenable to pharmacological treatment. Insomnia can be treated with short courses of hypnotics, again noting the risk of dependence on these agents.^{1,9,11} A 2022 systemic review and meta-analysis observed that mirtazapine may reduce the amount of methamphetamine consumed by patients with methamphetamine use disorder.²¹ Polysubstance abuse In those who are dependent on opioids and cocaine, the provision of effective substitution therapy for treatment of the opioid dependence with either methadone or buprenorphine can lead to a reduction in cocaine use.¹⁴ Psychosis associated with stimulant drugs Psychotic symptoms in association with methamphetamine are related to frequency of use and severity of methamphetamine dependence.²² In many, perhaps most, cases psychotic symptoms can resolve with the resolution of intoxication – i.e. over the course of a day or so. The majority of patients attending an emergency setting with acute psychotic symptoms in the context of very recent methamphetamine use can be managed with simple sedation (e.g. diazepam 5–10mg as needed 4–6 hourly for agitation) and therapeutic rest.²³ Some patients, however, may need more intensive treatment in line with the treatment of acute psychosis in Chapter 2. It should be noted that psychotic symptoms in the context of stimulant use are progressive with continued use – they tend to start earlier in each binge and to last longer. A median of 25% of patients report on-going symptoms 1 month after methamphetamine consumption.²⁴ Psychosis in the context of intoxication is associated with persecutory delusions and tactile hallucinations, while more persistent methamphetamine-associated psychosis is characterised by delusions of persecution and auditory hallucinations and is largely indistinguishable from a primary psychotic disorder.²⁴ In the emergency department it can be difficult to make a clear diagnosis. Between 16% and 38% of patients initially diagnosed with methamphetamine psychosis are later diagnosed as having schizophrenia.²⁴ In the acute setting, another important differential diagnosis in methamphetamine users presenting with agitated psychosis is GBL withdrawal delirium (where stimulant/ GBL polysubstance use is prevalent). There is symptomatic overlap between stimulant intoxication – autonomic hyperactivity, agitation,

hallucinations – and GBL withdrawal delirium. The latter requires higher doses of benzodiazepines and more prolonged treatment (see ‘GHB and GBL dependence’ later in this chapter). As already stated, in the emergency setting, simple sedation with benzodiazepines for agitation is often sufficient initially. If antipsychotics are indicated, the fourfold increased odds of developing extrapyramidal side effects (EPSEs) in patients who use methamphetamine should be borne in mind.²⁵ Agents with a low propensity to cause EPSEs should be used and there is evidence for efficacy of olanzapine. Aripiprazole may be preferred for rapid tranquillisation as olanzapine and benzodiazepines

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